STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	07/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITTENBERG LUTHERAN VILLAGE	1200 EAST LUTHER DRIVE CROWN POINT, IN46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00093516. Complaint IN00093516 substantiated, Federal/State deficiencies related to the allegations are cited at F 282 and F 309. Survey dates: July 25 and 26, 2011 Facility number: 000515 Provider number: 155608 AIM number: 100290820 Survey team: Janelyn Kulik, RN Census bed type: SNF/NF: 149 Total: 149 Census payor type: Medicare: 21 Medicaid: 80 Other: 48 Total: 149 Sample: 8 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2	F0000	Please let us know if this could be "Paper Compliance". Thank you,Tami Adams, Administrator 219-661-3301Tamara Zimmerman, DON 219-661-3354	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0282 SS=D	Quality review completed 7/28/11 Cathy Emswiller RN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview the facility failed to ensure physicians' orders were follow for IV(intravenous) antibiotics (medications used to treat bacterial infections) for 1 or 2 residents reviewed with orders for IV antibiotics in a sample of 8. (Resident #H) Findings include: The record for Resident #H was reviewed on 7/26/11 at 7:25 a.m. The resident was admitted to the facility on 7/8/11. The resident's diagnoses included, but was not limited to, chronic obstructive pulmonary disease, coronary artery disease, hypertension, endocarditis (infection around the hear), sepsis (blood infection), and lower leg edema (swelling). A Patient Medication Instruction Sheet form the hospital dated 7/8/11 at 9:21 a.m., indicated the resident was to receive Ampicillin (antibiotic) 2 g (grams) IV every four hours. The resident's next dose was due 7/8/11 at 11:00 a.m.	F0282	**F282 Services by Qualified Persons/Per Care Plan** 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Unable to correct the alleged deficient practice but Resident was sent to ER for his dose of antibiotics and Physician was aware. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** A chart audit was completed for any admissions or re-admissions from 6-26-11 through 7-26-11 with IV antibiotics ordered that could be affected by the same alleged deficient practice. A chart audit was completed for any admissions or re-admissions from 6-26-11 through 7-26-11 for timeliness of physician notification and timeliness of orders received for new admissions or re-admissions. Audit completed on 7-26-11 with no deficiencies. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.**	08/10/2011

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	Review of a physician order statement dated 7/8/11, indicated the resident was to receive Ampicillin 2 g every four hours at 3:00 a.m., 7:00 a.m., 11:00 a.m., 3:00 p.m., 7:00 p.m., and 11:00 p.m. Review of the July 8, 2011 medication administration record indicated the first does of Ampicillin was signed out as being given on 7/9/11 at 7:00 a.m. A nursing note dated 7/8/11 at 8:30 p.m., indicated the pharmacy called stating the resident's medications were coming tonight. The resident was informed his medications were coming. He asked why they were not here when he came into the facility. The nurse stated, "I would paged (sic) MD (medical doctor) to inform". On 7/26/11 at 1:30 p.m. the Director of Nursing was interviewed. She indicated the resident had received a dose of Ampicillin prior to the 7:00 a.m. documented dose given. She further indicated she knew the resident had received a dose of Ampicillin at 3:00 a.m. it just had not been signed out as given. On 7/26/11 at 1:45 p.m. the Director of Nursing and LPN #1 were interviewed. LPN #1 indicated she had taken the call from the hospital prior to the resident		Admission Medication/Treatment Orders policy revised on August 2, 2011 Admit audit revised on August 2, 2011 Preadmission Clinical Assessment – Nurse Liaison will document the name(s) of antibiotic(s) the physician ordered at the hospital along with the administration times. Preadmission Clinical Assessment – Nurse Liaison will document the time the last dose of antibiotics were given at the hospital prior to admission at the facility. All nurses will be in-serviced on the revised Administration Medication/Treatment Orders policy and the Preadmission Clinical Assessment on August 9, 2011 and August 10, 2011. h **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. Audit to be completed with each admission and readmission With in 24 hours of admission. This audit is required on every admission with no end date.** Quality Assurance Committee to monitor for Trends and Compliance.	

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	arriving at the facility. The hospital had indicated the resident was on two antibiotics but had not told the nurse the times the antibiotics were due to be given to the resident. She further indicated she paged the physician at 3:30 p.m. on 7/8/11 and reviewed orders with the physician at 4:00 p.m. She indicated the physician knew how frequently the resident was to receive the antibiotics and until she had his order she could not order the resident's medications from the pharmacy. She then indicated the physician should have known the resident would have missed doses of his antibiotic. This Federal tag relates to complaint IN00093516. 3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview the facility failed to provide (intravenous) antibiotics (medications used to treat bacterial infections) for 1 or 2 residents reviewed with orders for IV antibiotics for bacterial infections in a sample of 8 resulting in the resident returning to the hospital to receive antibiotics. (Resident	F0309	F309 Provide Care/Service for Highest well Being 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Unable to correct the alleged deficient practice but Resident was sent to ER for his	08/10/2011

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	#H) Findings include: The record for Resident #H was reviewed on 7/26/11 at 7:25 a.m. The resident was admitted to the facility on 7/8/11. The resident's diagnoses included, but was not limited to, chronic obstructive pulmonary disease, coronary artery disease, hypertension, endocarditis (infection around the hear), sepsis (blood infection), and lower leg edema (swelling). A Patient Medication Instruction Sheet form the hospital dated 7/8/11 at 9:21 a.m., indicated the resident was to receive Ampicillin (antibiotic) 2 g (grams) IV every four hours. The resident's next dose was due 7/8/11 at 11:00 a.m. Review of a physician order statement dated 7/8/11, indicated the resident was to receive Ampicillin 2 g every four hours at 3:00 a.m., 7:00 a.m., 11:00 a.m., 3:00 p.m., 7:00 p.m., and 11:00 p.m. Review of the July 8, 2011 medication administration record indicated the first does of Ampicillin was signed out as being given on 7/9/11 at 7:00 a.m.		dose of antibiotics and Physician was aware. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** A chart audit was completed for any admissions or re-admissions from 6-26-11 through 7-26-11 with IV antibiotics ordered that could be affected by the same alleged deficient practice. A chart audit was completed for any admissions or re-admissions from 6-26-11 through 7-26-11 for timeliness of physician notification and timeliness of orders received for new admissions or re-admissions. Audit completed on 7-26-11 with no deficiencies. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Admission Medication/Treatment Orders policy revised on August 2, 2011 Admit audit revised on August 2, 2011 Preadmission Clinical Assessment – Nurse Liaison will document the name(s) of antibiotic(s) the physician ordered at the hospital along with the administration times. Preadmission Clinical Assessment – Nurse Liaison will document the time the last dose of antibiotics were given at the hospital prior to admission at the facility. All nurses will be	

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	A nursing note dated 7/8/11 at 11:00 a.m., indicated the resident had arrived at the facility. He was alert and oriented times three, his speech was clear, skin warm and dry. His mucous membrane was pink and moist. His lung sounds were clear in the upper lobes with harsh rubbing sounds auscultated (heard) to bilateral lower lobes. He denied being short of breath. His oxygen was on at 2 liters per nasal canula. A double lumen PICC (peripherally inserted central catheter-used of IV access to be used over long periods of time) to his left arm with an intact dry dressing was noted. His abdomen was round with active bowel sounds in four quadrants. He had one plus edema to his bilateral lower extremities. His left foot was red and tender to touch. His vital signs were blood pressure was 120/46, temperature 97.8, pulse 81, and respirations 20. At 3:30 p.m. the physician was paged. At 4:00 p.m. the resident's orders were reviewed with the physician. At 8:00 p.m. the resident was in the recliner. He was alert and oriented times three, speech was clear, skin warm and dry and his mucous membrane was pink and moist. The resident indicated he will need little help outside of IV medications. A nursing note dated 7/8/11 at 8:30 p.m., indicated the pharmacy called stating the		in-serviced on the revised Administration Medication/Treatment Orders policy and the Preadmission Clinical Assessment on August 9, 2011 and August 10, 2011. h **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. Audit to be completed with each admission and readmission With in 24 hours of admission. This audit will be required for every admission with no end date.** Quality Assurance Committee to monitor for Trends and Compliance.	

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	resident's medications were coming tonight. The resident was informed his medications were coming. He asked why they were not here when he came into the facility. The nurse stated, "I would paged (sic) MD (medical doctor) to inform". At 8:50 p.m. the physician was paged with no reply. At 9:10 p.m. the resident's wife called and inquired as to why her husband had missed doses of his medication. The wife was informed of the problem and the resident's wife wanted the resident sent to the hospital for his medication. At 9:20 p.m. the physician was paged with no reply. The nurse practitioner was paged. Director MD ordered the resident to be sent out for one dose of IV antibiotics. At 9:25 p.m. the hospital was informed the resident was being sent to the hospital for one does of Ampicillin and was then coming back to the facility. At 10:00 p.m. the resident left per ambulance. At 11:30 p.m. the resident returned to the facility with wife from the hospital. The resident indicated he received one dose. Interview with Resident #H on 7/26/11 at 11:55 a.m., indicated the facility did not have his medication when he got to the facility . He had not been given his antibiotics and was sent back out to the hospital to receive his antibiotics. On 7/26/11 at 1:30 p.m. the Director of			

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	Nursing was interviewed. She indicated the resident had received a dose of Ampicillin prior to the 7:00 a.m. documented dose given. She further indicated she knew the resident had received a dose of Ampicillin at 3:00 a.m. it just had not been signed out as given. On 7/26/11 at 1:45 p.m. the Director of Nursing and LPN #1 were interviewed. LPN #1 indicated she had taken the call from the hospital prior to the resident arriving at the facility. The hospital had indicated the resident was on two antibiotics but had not told the her the times the antibiotics were due to be given to the resident. She further indicated she paged the physician at 3:30 p.m. on 7/8/11 and reviewed orders with the physician at 4:00 p.m. She indicated the physician knew how frequently the resident was to receive the antibiotics and until she had his order she could not send for the resident's medications from the pharmacy. She then indicated the physician should have known the resident would have missed doses of his antibiotic. She then indicated she was not sure what happened after the order for the medications was faxed to the pharmacy. The Director of Nursing indicated the nurse sent the order to the pharmacy as soon as she could have after she assessed the resident. There was no further information given as to why the			

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	assessment of the resident was documented at 11:00 a.m., the next does of the Ampicillin was due at 11:00 a.m. and the physician had not been contacted until 3:30 p.m. This Federal tag relates to complaint IN00093516. 3.1-37(a)			